UNITED
NATIONS

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Secretariat

ST/IC/1992/75
24 November 1992

INFORMATION CIRCULAR

To: Members of the staff at duty stations away from Headquarters

From: The Controller

Subject: VAN BREDA MEDICAL, HOSPITAL AND DENTAL INSURANCE*

1. The purpose of the present circular is to set out the provisions concerning renewal of the Van Breda medical, hospital and dental insurance plan for staff members at offices away from Headquarters, which will take effect on 1 January 1993.

2. The plan incurred a modest deficit during the 1992 policy period. In addition, the average level of reimbursement per participant rose slightly during 1992, reflecting increased levels of utilization and a rise in the costs of medical services world wide. As a result, the premiums for 1993 have had to be increased by approximately 4 per cent. This increase, however, is considerably lower than the 15 per cent premium increase which was implemented in January 1992. Staff members are reminded that the Van Breda plan is "experience-rated", which means that premium levels, and thereby the monthly amounts paid by staff members, as well as the related organizational subsidy, must be adjusted from policy period to policy period to ensure that total premium income is sufficient to meet the expected reimbursement expenses of the plan.

3. In addition to the 4 per cent premium increase, the key provisions of the renewal for 1993 are:

(a) Elimination of the "prior notification" requirement relating to hospitalization in the United States of America, in effect since January 1992 (see paras. 6 and 7 below, and annex II);

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* Personnel Manual index No. 6190.

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(b) An increase in the maximum reimbursement for hearing-aids from $150 to $300 per apparatus (see para. 8 below, and annex I, para. 2 (g) (i));

(c) An increase in the maximum reimbursement for optical lenses from $25 to $30 per lens (see para. 9 below, and annex I, para. 2 (g) (ii)).

4. The schedule of premiums which will become effective on 1 January 1993 as well as the related staff contribution rates are set out in the tables below:

Premium levels

| | Monthly premiums (United States dollars) | |
|---|---|---|
| Type of coverage | Current | Effective 1 January 1993 |
| Staff member only | 71.00 | 74.00 |
| Staff member and one family member | 150.00 | 156.00 |
| Staff member and two or more eligible family members | 247.00 | 257.00 |

Staff contributions

| | Percentages of medical net salary | |
|---|---|---|
| Type of coverage | Current | Effective 1 January 1993 |
| Staff member only | 1.18 | 1.18 |
| Staff member and one family member | 1.92 | 1.92 |
| Staff member and two or more eligible family members | 3.03 | 3.03 |

5. In line with the methodology used in the calculation of staff contributions towards premiums for other United Nations insurance schemes, the contributions of participants in the Van Breda scheme are calculated as a percentage of their respective medical net salaries in accordance with the rates set forth above. Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the premiums shown above.

## Hospitalization in the United States

6. As set out in ST/IC/1991/73, the "prior approval" requirement pertaining to non-emergency hospitalization in the United States was dropped effective 1 January 1992. That mechanism was replaced by a new arrangement under which a "cap" of US$ 700 applied to the daily semi-private hospital room rate for hospitalization in the United States. Participants were also required to provide written notification to Van Breda of their intention to be hospitalized in the United States in order to avoid certain reimbursement penalties. The arrangements introduced on 1 January 1992 were established on a trial basis.

7. As of 1 January 1993, the "prior notification" procedure will be eliminated. However, the US$ 700 limit will continue to apply to the daily semi-private hospital room rate. Details concerning the application of the US$ 700 limit on hospitalization in the United States are set out in annex II to the present circular.

## Hearing-aids and optical lenses

8. With effect from 1 January 1993, the cost of hearing-aids will be reimbursed at 80 per cent, with a maximum reimbursement of $300 per apparatus. The $300 maximum includes the cost of any related audiometric examinations. In addition, as heretofore, a maximum of one apparatus per ear will be recognized for reimbursement in any period of three years.

9. With effect from 1 January 1993, the cost of optical lenses will be reimbursed at 80 per cent with a maximum of $30 per lens and, as heretofore, with a maximum of two lenses in any period of two years.

## Second surgical opinion

10. As announced in ST/IC/1991/73, a second surgical opinion in connection with 16 surgical procedures ceased to be required with effect from 1 January 1992. This meant that Van Breda would no longer implement a reimbursement penalty for failure to obtain a second surgical opinion in connection with these procedures. This provision is maintained in the 1993 renewal. However, participants continue to be strongly encouraged to seek a second surgical opinion whenever possible to obtain such opinion from a qualified independent physician. Thus, while a second surgical opinion is no longer a requirement, Van Breda will continue to reimburse at the rate of 100 per cent expenses incurred in obtaining second opinions regarding any of the 16 procedures listed in annex III to the present circular.

## Basis for claim reimbursement in United States dollars

11. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Up to 31 December 1989, reimbursement was based upon the United Nations operational rate of exchange in effect on the date the claim was signed. Since 1 January 1990, reimbursement in United States dollars has been based on the United Nations operational rate of exchange in effect on the date the medical and dental expenses were incurred, and in the case of hospital expenses, on the date the hospital bill was rendered.

## Conversion privilege

12. Participants who cease employment with the United Nations and who do not qualify for after-service health insurance benefits may arrange for medical coverage with Van Breda under an individual contract, provided that application is made within 31 days of termination of coverage under the United Nations group policy. The conversion privilege, which is part of the United Nations group contract with Van Breda, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. The conversion privilege, however, does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts. Participants should bear in mind, however, that under the conversion privilege, dependants may only apply for individual coverage at the same time as the staff member, upon cessation of employment with the United Nations. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Van Breda at the following address:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, Belgium

Telex No.: BREDCO B 31788
Fax No.: 00 323 271 02 47 (facsimile transmission)
Telephone No.: 00 323 217 5111

## Eligibility for enrolment in the Van Breda plan

13. Except for staff members whose duty station is New York, Geneva or Vienna and locally recruited staff members at duty stations where the Medical Insurance Plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 or 200 Series of the Staff Rules may enrol themselves and eligible family members in the United Nations Van Breda plan. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. The enrolment of eligible

family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the P.5 personnel action form.

## Eligible family members

14. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

## Enrolment at times other than upon entry on duty

15. Staff members appointed under the 100 Series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty (EOD) have an opportunity one time each year to do so. The annual enrolment period generally is set for the first week of June, the specific dates being announced each year sufficiently in advance of the occasion. The effective date of insurance coverage which is applied for during the annual enrolment week is the first day of the following month.

16. Staff members appointed under the 200 Series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance scheme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance scheme provided by the United Nations, may enrol their spouses and dependent children in the scheme. Project personnel who have not enrolled their spouses or eligible dependent children in the Van Breda plan at the time of initial appointment have an annual opportunity to do so. In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty and insurance coverage for added dependants will be effective as of that date.

17. At times other than the annual enrolment periods referred to in paragraphs 15 and 16 above, staff members (100 or 200 Series) and their eligible family members may be enrolled in the Van Breda plan only if at least one of the following events occur and application for enrolment is made within 31 days thereafter:

(a) Upon transfer from one duty station to another;

(b) Upon return from Special Leave Without Pay (SLWOP) (see para. 20 below);

(c) Upon assignment to a mission under certain conditions (see para. 21 below);

(d) Upon marriage, birth or legal adoption of child for coverage of the related family member; and/or

(e) Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

18. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraph 17 above or not received within 31 days of the event giving rise to eligibility will not be receivable. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment opportunity periods, the staff member must wait until the next annual opportunity to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in the United Nations scheme during the established annual enrolment period.

Staff transferred to another duty station

19. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment will be in one of the health insurance plans offered at Headquarters. Staff members are reminded that if they transfer from one duty station to another and in the process are transferred from one payroll system to another, they should, upon arrival at the new duty station, ensure that their insurance coverage is recorded in the new payroll system so that the deduction of monthly premium contributions may be continued without a break.

Staff on special leave without pay

20. Staff members who are granted special leave without pay are reminded that they may retain health insurance coverage during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Section (if payrolled at Headquarters) or the

relevant administrative office (if payrolled elsewhere) MUST be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the administrative office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage while on special leave without pay, no action is required upon commencement of the special leave;

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage during a period of special leave without pay, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

## Staff members assigned on mission

21. In view of the large number of staff members going on mission assignment, it has been decided to extend a special health insurance enrolment opportunity to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are not enrolled in the Van Breda plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in the plan in these circumstances must be completed prior to the departure of the staff member on mission assignment;

(b) Staff members who elect to enrol in the Van Breda plan in the circumstances set out in (a) above forego the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Van Breda plan or change their present coverage, as provided above, must present evidence to the Insurance Section or to their administrative office, as the case may be, of the mission assignment and its duration.

Staff member married to another staff member

22. Staff members are reminded that in the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.

Staff members with dependants residing in the United States

23. Staff members are reminded that the Van Breda plan is designed to provide medical, hospital and dental coverage for participants stationed outside the United States. Therefore, staff members stationed outside the United States but with eligible dependants residing in the United States may wish to enrol instead in the Blue Cross/Aetna Major Medical insurance plan. As the Blue Cross/Aetna Major Medical plan does not include dental coverage, participants may also wish to subscribe to the (optional) Group Health Incorporated (GHI) dental plan. While it is not required that staff members with eligible dependants residing in the United States enrol in a Headquarters plan, it should be borne in mind that persons not covered by a United States insurance company may not be admitted to hospital unless expenses are prepaid or guaranteed by Van Breda. The US$ 700 daily hospital room rate limit will also apply (see paras. 6 and 7 above). In addition, in emergency situations, evidence of coverage by a recognized United States insurance company (in the case of the United Nations, Blue Cross) is usually required to ensure hospital admission. However, with effect from 1 January 1993, staff members with eligible dependants residing in the United States may switch their coverage to the Headquarters plan(s) only during the annual enrolment opportunity period, and must present evidence of the United States residency of the eligible dependants concerned.

Cessation of coverage of family members

24. The Insurance Section at Headquarters or the relevant administrative office should be notified immediately in writing of changes in the staff member's family which result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the age of 25 years, marrying or taking up full-time employment. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (e.g., from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Section or administrative office.

## After-service health insurance

25. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. Full details on the eligibility requirements for after-service health insurance coverage are given in the relevant administrative instructions. 1/ It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the after-service health insurance programme.

## Where to address claims and benefit inquiries

26. Although the staff of the Insurance Section is available to assist staff members in administrative matters concerning participation in the Van Breda plan, claims questions should always be taken up in the first instance directly with the insurance company concerned. The address and telephone, telex and fax numbers of Van Breda are provided in paragraph 12 above.

27. Annex I to the present circular sets out a summary of the benefits payable under the Van Breda plan.

28. Annex II contains a recapitulation of the provisions pertaining to hospitalization in the United States.

29. Annex III sets out relevant details concerning the second surgical opinion requirement.

## Notes

1/ ST/AI/172, ST/AI/172/Amend.2 and 3 and ST/AI/172/Add.2.

## Annex I

## VAN BREDA INSURANCE SCHEME

1. The Van Breda insurance scheme provides for reimbursement of medical, hospital and dental treatment costs up to a maximum of $200,000 per insured participant per calendar year. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also be applied on the basis of a determination of reasonable and customary charges for the benefit at the place of treatment.

2. The scheme is subject to the following provisions and limitations:

(a) Under the basic component, reimbursement in respect of medical treatment prescribed by qualified doctors is limited to 80 per cent of the costs incurred, including doctors' fees. Under the major medical component, 80 per cent of the remaining unpaid costs is paid, subject to a co-payment of $200 per participant and $600 per family;

(b) The cost of hospital services (excluding doctors' fees) is reimbursed at the rate of 100 per cent of the costs involved, including such items as bed and board, general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care (i.e., two or more patients in the same room), except that, under the following circumstances, private-room care will be reimbursed in full:

(i) When the nature and gravity of the illness requires private-room care and such care is requested by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, i.e., it has no standard of accommodation other than private rooms and general wards.

Europe and North America are defined for this purpose as Europe, including Eastern Europe, Malta, Cyprus and Turkey (European portion), and Canada and the United States of America;

(c) The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $750 per insured participant per calendar year. The cost of dento-facial orthopaedics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years;

(d) The cost of out-patient mental health treatment, including psychoanalysis, is normally only reimbursable if the patient is treated by a medical doctor engaged in the practice of psychiatry. However, upon referral by a psychiatrist or, in localities where a psychiatrist is not available, by a qualified physician, the services of a licensed psychologist or a licensed psychiatric social worker will be covered. The costs of psychiatric treatment in respect of insured participants is reimbursable at the rate of 50 per cent and to a maximum reimbursement of $500 for not more than 50 visits per insured person in any consecutive six-month period;

(e) The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes in-patient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers out-patient counselling for the purpose of diagnosis and treatment. The costs of out-patient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem;

(f) The cost of radiological treatment is reimbursable at the rate of 80 per cent only if the patient has been referred to the specialist by the doctor in attendance;

(g) The cost of hearing-aids and optical lenses is covered, with the following limitations:

(i) Hearing-aids. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear in any period of three years;

(ii) Optical lenses. Reimbursement at 80 per cent (only basic coverage, no major medical coverage) with a maximum of $30 per lens and a maximum of two lenses in any period of two years.

In order to be entitled to these benefits, a staff member or the participating family member will have to have been a participant in the Van Breda scheme for one year or more;

(h) The cost of two blood tests per year for the human immunodeficiency virus (HIV).

3. The insurance scheme does not cover:

(a) Periodic preventive health examinations;

(b) Examination of the eyes for optical lenses (eyeglasses or contact lenses);

(c) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(d) Insured participants who are mobilized or who volunteer for military service in time of war;

(e) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(f) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(g) Spa cures, rejuvenation cures or cosmetic treatment (cosmetic surgery is covered, however, where it is necessary as the result of an accident for which coverage is provided);

(h) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(i) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded.

4. In respect of the 16 surgical procedures listed in annex III to the present circular, the cost of a second opinion will be reimbursed at 100 per cent and, should a participant desire a third opinion, the cost of that opinion will also be reimbursed at the rate of 100 per cent. No penalty will be assessed in cases in which surgery is performed without the benefit of a second opinion.

5. Subscribers should note that claims for reimbursement must be submitted to Van Breda no later than two years from the date on which the medical expense was incurred. Claims received by Van Breda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.

## Annex II

## PROVISIONS PERTAINING TO HOSPITALIZATION IN THE UNITED STATES

1. A prior approval measure was introduced on 1 March 1988 to control the frequency of hospitalization within the United States, where overall costs frequently run far above the costs for comparable medical services in other countries. With effect from 1 January 1992, prior approval from Van Breda for hospitalization in the United States was no longer required. Instead, under a new arrangement which was introduced on a trial basis, the participant was obliged only to notify Van Breda of his or her intention to be hospitalized in the United States. With effect from 1 January 1993, the "prior notification" requirement is being dropped from the plan.

2. While a participant is free to seek admission to a United States hospital without providing any notification to Van Breda, reimbursement for such hospitalization will continue to be subject to a limit of $700 in respect of the daily semi-private room rate. Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $700, the cost of the daily room rate above $700 will be borne entirely by the participant. There will be no change in the reimbursement for other services. In this connection, it should be noted that hospital costs vary considerably throughout the United States, and costs may exceed the $700 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C., where the costs may be much higher in certain hospitals.

3. The $700 limit will not apply to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

(b) In cases of bona fide medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $700. To avoid the obligation to meet daily room-rate expenses in excess of $700 in such cases, confirmation must be obtained from Van Breda prior to the hospital admission.

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## Annex III

## SECOND SURGICAL OPINION REQUIREMENT

1. With effect from 1 January 1992, participants were no longer required to obtain a second opinion prior to undergoing surgery. As of that date, no reimbursement penalty has been assessed by Van Breda for failure to provide evidence of a second opinion in connection with any surgery. However, whenever feasible, participants are encouraged to seek a second surgical opinion, particularly for the 16 surgical procedures listed below. For this reason, Van Breda will continue to reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought, and will also be fully reimbursed. Please note that the second opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery.

2. The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:

| | Procedure | Explanation |
|---|---|---|
| 1. | Bunionectomy | Removal of bunions |
| 2. | Cholecystectomy | Removal of gall-bladder |
| 3. | Dilation and curettage | Dilation of cervix and scraping of uterus |
| 4. | Excision of cataracts | Removal of cataracts |
| 5. | Haemorrhoidectomy | Removal of haemorrhoids |
| 6. | Hernia (inguinal) repair | Repair of hernia in the groin |
| 7. | Hysterectomy | Removal of uterus |
| 8. | Knee surgery | Knee operation |
| 9. | Laminectomy | Removal of part of spine |
| 10. | Mastectomy: partial or complete | Partial or complete removal of breast tissue |
| 11. | Prostatectomy | Removal of prostate |
| 12. | Septo-rhinoplasty | Nose surgery for functional improvement |

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| | Procedure | Explanation |
|---|---|---|
| 13. | Spinal fusion | Surgical welding of spine segments |
| 14. | Tonsillectomy and/or adenoidectomy | Removal of tonsils and/or adenoids |
| 15. | Varicose veins | Removal and tying of varicose veins |
| 16. | Coronary artery bypass | Heart surgery to bypass one or more blocked arteries feeding the heart |

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